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PHM/SRG-54(RB-5)

WEMOS
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HEALTH FOR ALL

Good Intentions with Side-Effects

Information on Global Public Private Initiatives in Health: GPPIs

CPHE

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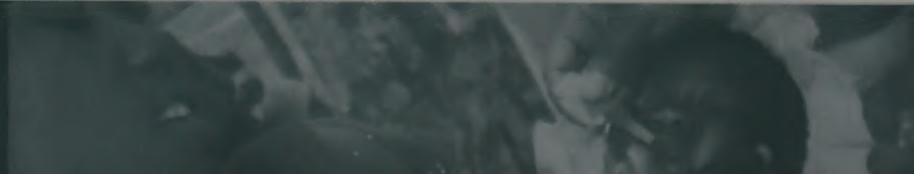
1. Introduction and highlights

The health situation of poor people in low and lower middle income countries is a matter of great concern. Millions of people do not have access to sufficient food, safe drinking water, adequate housing and health care. Large numbers of people die every day of preventable and treatable illnesses. As a response to the present health crisis, UN health related agencies are increasingly appealing to companies and rich individuals to provide funds and other resources for the improvement of people's health in poor countries. Together with UN bodies such as the World Health Organisation (WHO) and governments, they are engaging in a growing number of so-called Global Public Private Initiatives or Partnerships (GPPIs).
Partnerships between the public and the private sector are not new; its international dimension has, however, created a relatively new phenomenon.

At this moment, there are around 80 GPPIs working in the field of health, and new partnerships are launched regularly. In Tanzania, 28 partnerships are implementing activities. In Uganda 25 partnerships are active, in Mali 24 and Zambia, Mozambique and Senegal count 23 global partnerships. Most of them focus on the development of a product (e.g. development of a vaccine) or the improvement of access to health products (e.g. access to medicines for leprosy). 13 of these partnerships are focussed on different aspects of malaria, 12 on HIV/AIDS and 9 on tuberculosis.

This booklet has been compiled within the framework of the Wemos project 'Health and the Private Sector'. Wemos is of the opinion that an integrated approach to health is needed to ensure the fulfilment of the right to health for all. This implies, amongst other things, the need for strengthening of health systems that guarantee accessible health services for all and are based upon the needs of the people they are meant to serve.
That large companies and rich individuals are willing to take responsibility for fighting the ill-health of millions of people is a positive development. The question is whether the present GPPIs are an effective way to improve people's health.

As part of this project, a series of case studies is being carried out by Southern partner organisations in order to shed light on the performance of some GPPIs programmes at country level and the consequences of these programmes for local health systems.
In Uganda, Tanzania and Zambia, Roll Back Malaria is investigated. In South Africa, one of Wemos' partners is looking at Stop TB.
A Kenyan partner organisation is doing research on the Global Alliance to Eliminate Lymphatic Filariasis and in India the Global Polio Eradication Initiative and the Global Alliance to Eliminate Lymphatic Filariasis are being investigated. The results of these studies will be available in the summer of 2004.



This booklet is based on a study carried out in 2003 on behalf of Wemos. 79 GPPIs were studied, most involving the WHO.
The researchers used information available on the websites of GPPIs themselves, their partners, non-governmental institutions (NGOs) and independent reports. Out of the 79, 10 were selected to be studied in more detail, looking at aspects such as their objectives, which public and private institutions are involved and how decisions are made and implemented.

'In India, 40 percent of the population lives below the poverty line. We welcome new partnerships, but they will have to work. They have to work for the people.'
Mr. Poddar, West Bengal Voluntary Health Association, India

Good intentions with side-effects, drawing on the results of the research, is aimed at giving an idea of what exactly partnerships are and what their side-effects might be. The booklet includes a close look at one of the largest and most influential GPPI, the Global Alliance for Vaccines and Immunisation (GAVI). Also, an overview is given of the 79 GPPIs that were studied, and 10 partnerships are described in more detail.

2. GPPIs

What are they?
Objectives, strategies and activities

Looking at the objectives, activities and strategies of 79 GPPIs reveals an overriding emphasis on a specific disease, linked to the access to, or development of a specific drug or vaccine. Typical too will be a clearly expressed target like '50 percent reduction' or 'eradication'. Diseases commonly targeted are malaria, tuberculosis (TB), HIV/AIDS and other infectious diseases. Almost half concern development or access to drugs, vaccines and other health products. By contrast little more than one in ten states strengthening health services as one of their objectives.

Who are they? Main participants

Public

WHO and UNICEF are the principal international governmental or multilateral organisations, having a stake in respectively 62 percent and 33 percent of all global partnerships in health. Typically the WHO takes responsibility for high-level technical decisions while UNICEF plays a more operational role driven by the number of vaccine-related GPPIs and the high burden of disease borne by children. GPPIs are seen as an important way for UN organisations to increase access to funding. UN secretary general Kofi Annan told the World Economic Forum in 1999 that prosperity could not be achieved without partnerships involving the business community. The World Health Organisation's ex-director Gro Harlem Brundtland argued too that the complexity of today's health requires all sectors to pull together, including business. In this context, the WHO developed 'Guidelines on working with the private sector'. These guidelines were intended primarily to help WHO staff interact appropriately with commercial enterprises and avoid conflict of interest.

The World Bank is also an important multilateral player, mostly acting as a custodian of funds managed by a GPPI. For governments of low income countries, GPPIs represent another source of financial and technical support for their activities in health. Health budgets often amount to less than 13 US dollar per person per year (1) and many governments argue that any outside funding is welcome to fight the present health crisis. The WHO Commission on Macro-economics and Health estimates that at least 30 to 40 US dollar per person per year is needed to cover essential interventions, including those needed to fight the AIDS pandemic.

Private

The most common philanthropic foundations are the Bill and Melinda Gates Foundation and the Rockefeller Foundation, with Gates by far the most involved. The pharmaceutical companies GlaxoSmithKline (GSK) and Merck are the most common of a concentrated group of six commercial pharmaceutical companies. Private capital's involvement may be both socially responsible and purely economic. Transnational companies have become so

WHO and Unicef have a stake in respectively 62 percent and 33 percent of all global partnerships in health

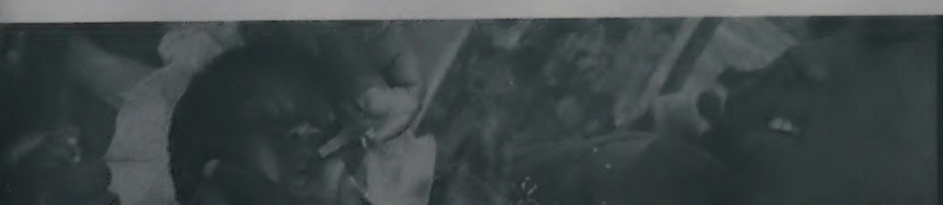
large and powerful that it is almost inevitable they will touch on larger social questions such as AIDS/HIV and malaria. Shareholders will demand an increased sense of social responsibility and businesses would rather not operate in the global insecurity posed by the threat of diseases such as HIV/AIDS. But unlike previous "donations", "partnerships" suggest a degree of leverage. All partners, including private capital, have a say in decisions and have interests, which should be addressed. And companies have much to gain. GPPIs can carve out new markets for the future; vaccines can be introduced to the business potential of the developing world. GPPIs can also boost the public image of a company, becoming a part of its whole corporate planning.

NGOs are typically being involved in GPPIs because of their presence in a particular target country. Médecins Sans Frontières (MSF) and the Programme for Appropriate Technology in Health (PATH) are the most common, playing a role in GPPIs they themselves have launched. Other participants include developed country government departments such as USAID and academic institutions such as the London School of Hygiene and Tropical Medicine.

And How?
Organisational arrangements

The research of ten GPPIs showed most were organised through an international board that usually meets infrequently to consider large funding allocations, strategic direction and changes in objectives. Typically the GPPI boards take funding decisions in response to proposals from recipient countries. These have been made according to a set framework previously established by the donors.

Other research on GPPIs governing structure reveals that certain groups are systematically under-represented in governing bodies of GPPIs, particularly Southern governments and civil society organisations (2). The Global Alliance to Improve Nutrition (GAIN) is an exception in this respect. GAIN gives poor countries a 40 percent stake, while the rest including private industry, private foundations, NGOs, bi-and multi-lateral agencies such as the UN and scientific agencies have 10 percent each. However, the voting rights structure does not provide the full picture of the power structure within GPPIs. While drug companies may not have a majority of votes on a GPPI board, they exercise huge influence over decision making, because without their continued and voluntary donations many GPPIs would simply collapse.



GPPIs are almost always based in Western countries: their headquarters are close to those of the private company or multilateral agency that launched them. Of the 79 GPPIs studied, only four had a headquarter based in a recipient country. Due to the costs of travel, some authors suggest that partners or potential partners from poor countries may be at a disadvantage to participate in decision making processes.

How much money is involved?

Though it is quite difficult to obtain information on the exact budget of GPPIs, it is possible to make a rough estimate using different sources. For example, the Global Polio Eradication Initiative has spent 2 billion US dollar since 1985. Her budget for 2002 until 2007 is about 1 billion US dollar. The Global Alliance for the Elimination of Lymphatic Filariasis has an annual budget of about 100 million US dollar. Roll Back Malaria could spend 165 million US dollar in 2002. The Stop TB partnership has a budget of around 600 million US dollar per year. The Global Alliance for Vaccines and Immunisation has had about 1,14 billion US dollar to spend since 2001. In comparison: the total budget of the WHO for 2004-2005 is 2,8 billion US dollar.

Which information is available?

The amount of information published on the GPPI's websites depends partly on the size and public profile of the GPPI. For example, the collaboration between Japanese pharmaceuticals, the ministry of health and the WHO's malaria venture, a relatively small GPPI, appeared to be hardly documented on the web.

By contrast the Global Alliance for Vaccines and Immunisation (GAVI) publishes extensive information on its website including its objectives, a progress report, and the names and roles of board and secretariat members.

The researchers conclude that GPPIs rarely publish much information on finances and progress towards their aims. What they do publish is an overriding focus on easy to measure targets, such as the number of persons covered by immunisation or receiving a specific treatment.

GPPIs are almost always based in Western countries

Polio
(Also called "Poliomyelitis")
Polio is a Sickness
which begins with a
Mild Cold,
Arms or Legs
become Lame,
thin wasted with
normal sense to touch

3. Good intentions with side-effects

This study and earlier studies on GPPIs show that some have had positive outcomes. They deliver funding, draw attention to largely unknown health threats such as river blindness, and some have been very successful in achieving their goals. For example, one of the earliest GPPIs, the Global Polio Eradication Initiative has made great gains in eradicating the disease in almost every region of the world.
But there are risks too. The main risks associated with GPPIs concern their sustainability, governance and accountability.

Sustainability

In discussions about the increasing importance of GPPIs, questions are often raised about the sustainability of the funding and of the health improvements. GPPIs rarely include explicit financial commitments of the commercial sector beyond five years. Merck's donation of the drug Mectizan, in the framework of the Mectizan Donation Programme, is remarkable for explicitly stating that the donation is indefinite. With other GPPIs, this is not the case. If, for example, in the framework of the Global Alliance for the Elimination of Lymphatic Filariasis, the pharmaceutical company GSK decided to withdraw its commitment to donate the drug albendazole to a specific country, then the initiative would stop. Poor countries cannot insist on the support of GSK. A commitment to donate is not enshrined within any governance documents available. Without it the GPPI, invested in by the country's health system and requiring a commitment over many years, would collapse.
Dependency on new, sometimes more expensive drugs or vaccines, also affects the sustainability of the partnership. In the case of the Global Alliance for Vaccines and Immunisation, Ghana has accepted a more expensive vaccine (pentavalent) because the cheaper quadravalent version was not available at that moment. If the GPPI would stop and the government would have to continue the programme, they have to spend a large part of their budget on these vaccines and other health priorities could suffer.

Another example is the Accelerating Access Initiative (AAI), which aims to reduce the prices of HIV/AIDS medicines. According to Act Up Paris, the pharmaceutical companies working in the AAI let countries sign confidential agreements that aim to prevent competition with generic HIV/AIDS medicines (3). The absence of generic medicines makes countries fully dependent on the willingness of international pharmaceutical companies to offer their medicines at a lower price. If these companies decide to increase their prices, governments have no alternative and are forced to purchase these more expensive patented medicines.

Finally, the number of GPPIs operating in one single country and the number of these GPPI programmes directed to the same health

problem might pose questions about sustainability and efficiency.
Especially because each partnership works with a different perspective and with a different approach, but makes use of the same health system to implement their plans.
When these programmes are not well coordinated, it might lead to overuse of the already weak health system. Then the situation could arise that a country does have access to the medicines it needs, but lacks the infrastructure to deliver it to the patients.

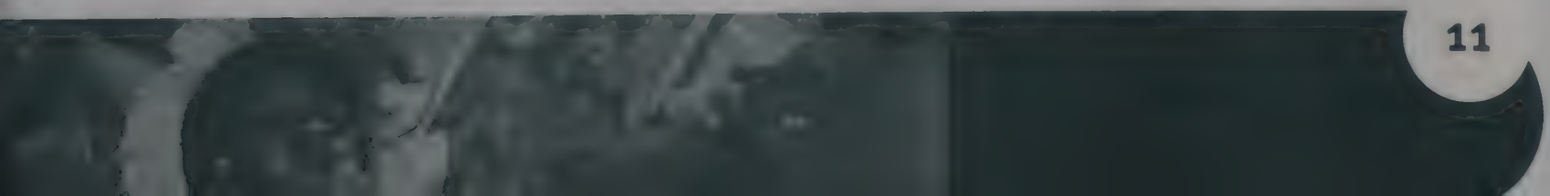
Governance and accountability

Another 'hot item' is the way in which GPPIs are governed. This whole question of "governance" is attracting attention as it is breaking new ground. For the first time on a global scale, public, commercial and civil society are being brought together through partnerships to achieve shared health goals. Related to this is the issue of transparency and information about the operational structure, decision making processes and accountability mechanisms for GPPIs.

Though a sufficiently wide group of stakeholders is normally in place to make decisions (for example, the Stop TB partnership counts more than 200 partners), this does not guarantee democratic decision making.
So far, research concludes a gross underrepresentation of stakeholders from poor countries and a lack of specific criteria for defining the "rights, privileges and obligations associated with partners status"(4). Most decision-making power sits in the hands of multilateral institutions and the commercial sector. By contrast, poor countries' governments have less of a voice in the formation and design of GPPIs.

Some researches state that accountability in partnerships is complex and contested. Complex, because it involves the accountability of the executive staff to the governing body of the GPPI, of the governing body to its stakeholders, and of the partners of the GPPI to the GPPI itself. Contested, because opinions differ whether these partnerships need to be accountable only to the donors and main stakeholders or need to be accountable to any social group affected or involved in the GPPIs' programmes. The lack of representation of the target population in decision making mechanisms makes these partnerships very low accountable to populations to whom they are directed.

The main risks associated with GPPIs concern their sustainability, governance and accountability



4. An example: The Global Alliance for Vaccines and Immunisation (GAVI)

GAVI was launched in January 2000 at the World Economic Forum in response to international concern over a decade of declining childhood immunisation rates. This decline had had a devastating effect on child mortality. GAVI brought together an alliance of national governments, the WHO, UNICEF, the World Bank, the Bill and Melinda Gates Foundation and industry, represented by the International Federation of Pharmaceutical Manufacturers' Associations. It aimed to provide a new mechanism for coordinating partner organisations' efforts to revitalise international support for immunisation.

Turning back the tide on childhood disease

In 1974 the World Health Assembly had launched The Expanded Programme on Immunisation (EPI) which achieved real successes. By 1980 UNICEF could report that immunisation rates against the six major childhood diseases, diphtheria, tetanus, whooping cough, polio, measles and tuberculosis, had leapt from 5 percent to 80 percent. It then stalled and began to fail. This was caused by a variety of inter-related reasons including war, HIV/AIDS, donor fatigue and a change of leadership at the WHO. By 2000, global coverage on immunisation had dropped to 75 percent. In 19, mostly African countries, immunisation rates against diphtheria, tetanus and polio had dropped below 50 percent. Yet as early as September 2003, GAVI could claim that 30 million of the world's poorest children had benefited in just three years. 250 million US dollar had been distributed among 60 countries and an estimated "300,000 deaths had been prevented" (5).

As early as September 2003 GAVI could claim that 300,000 deaths had been prevented

New initiative, new methods, new money

GAVI is significant as one of the first of the new GPPIs launched in the last five years. It is also one of the biggest and is mostly funded by the largest private donor, the Bill and Melinda Gates Foundation, that committed US$ 750 million. There was also support from national governments, ranging from the United States (US$ 159 million over three years), the Netherlands (US$ 85 million over five years), to Ireland (US$ 0.5 for one year). While a board sets its overall objectives, structures and recommendations for funding, a separate and mutually interdependent Vaccine Fund has the final say on applications to the GAVI. A stated additional aim of this Fund is to "demonstrate to vaccine manufacturers that a developing country market exists for newer vaccines".

Unlike many GPPIs, it spelt out clear objectives. These include expanding the use of existing under-utilised vaccines in 74 countries, supporting the development of new vaccines, improving access to sustainable immunisation services, expanding the use of existing cost-effective vaccines and promoting the delivery of other appropriate interventions at immunisation centres. It also spelt out clear goals. These included that 80 percent of poor countries would have at least 80 percent routine immunisation coverage by 2005. Also specific targets were added for hepatitis B (hep B) and haemophilus influenzae type b (Hib) vaccination.

GAVI is significant as one of the first of the new GPPIs launched in the last five years

Return to immunisation

A report by UK-based NGO Save the Children looked in 2001 at how GAVI actually worked on the ground in four countries: Ghana, Mozambique, Tanzania and Lesotho.
In general they welcomed the renewed focus on immunisation, the strengthening of countries' immunisation coordinating committees, the introduction of safe injections and equipment for hepatitis B vaccine, and the provision of technical support. Countries particularly welcomed the freedom GAVI allowed, in contrast to other donors, in the way money was spent on supporting health systems. Welcome too was the chance GAVI offered to provide hepatitis B vaccine, which countries had previously wanted but found too expensive.

There was also evidence that GAVI was getting feedback and learning from individual country's experience. The "evolutionary" aspect of GAVI has been praised.

One example is the decision to provide auto-disposable syringes for all vaccines in the expanded programme and not just for new vaccines. This helped allay fears that re-usable syringes could put their children at risk from HIV.

However, critical remarks have been made about the limited attention paid to strengthening the infrastructure needed to vaccinate children. Health Action International Europe, for example, noted that among the first awards in 2000/2001 only 10 percent were for strengthening immunisation services while 90 percent were for developing and introducing new vaccines, mainly hep B (6). A good sign is that in the proposals for 2002 this percentage had increased: 28 percent of the total budget was awarded to strengthening of immunisation delivery systems (7).

Risks

All the benefits of the GAVI programme could be jeopardised by its over dependence on the inadequate systems currently operating. Because it is incorporated into routine immunisation services it may suffer from the same chronic under-investment. Examples from the Save the Children report speak of broken fridges and thermostats, a lack of fuel for transport, staff shortages and inadequate facilities for disposing of syringes. Much of rural Mozambique, for example, has no adequate cold chain equipment to store the vaccines. With these crippling problems, efforts to extend immunisation coverage and ensure supervision and monitoring, an important aim of GAVI, are threatened. GAVI's system support funds alone cannot hope to redress such structural weaknesses and attention should be paid to more sustainable health system improvements in order to achieve the GAVI objectives.

The Save the Children study raises serious concerns about sustaining funding for the GAVI after its initial lifespan of five years. A notable finding, it concludes, is a lack of discussion and co-ordination about future financing. It sees little evidence that individual agencies will meet future costs especially, for example, where countries have opted for expensive combination vaccines. The current cost of Ghana's expanded programme on immunisation is $US 3.7 million a year. This will treble with the introduction of the pentavalent vaccine, which is part of the GAVI programme in Ghana. If GAVI would decide to stop its activities in Ghana, it may be politically damaging for the government to withdraw from costly programmes such as the pentavalent vaccine programme. As a result, other greater health priorities could suffer.

5. Concluding remarks

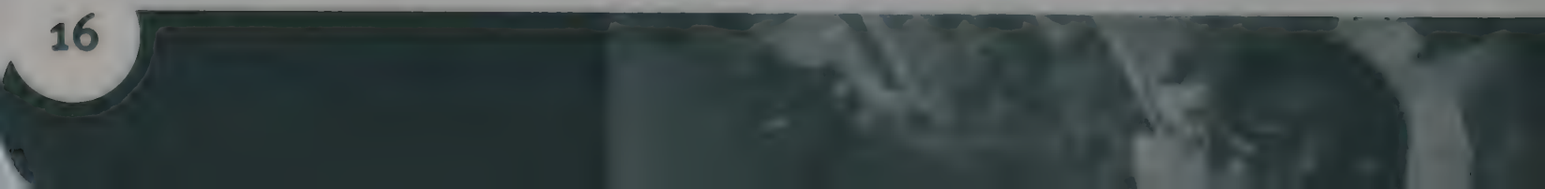
In this booklet, a brief introduction to GPPIs in health has been provided. It is too early to have in-depth insight into the effects of GPPIs. More research on the performance of GPPIs at country level is needed in order to decide whether the present GPPIs are an effective way to improve people's health in poor countries and if not, what should be done to improve their effectiveness. The Wemos' case studies, available this summer, will provide more information.

In the mean time, based on the available information, Wemos proposes a series of clear criteria that can be used to assess whether GPPIs are an effective instrument in improving people's health:

- Participation – Is the strategy and approach of the GPPI the result of consultation with the recipient country? Does it reflect their main priorities?
- Sustainability – Does the GPPI strengthen local health system structures, enabling people to help themselves in the future? Does the GPPI look beyond its set time frame? Does the GPPI give attention to prevention and the cause of the targeted disease?
- Accountability – Is the GPPI accountable to the public? Is the decision making process transparent? Are the WHO guidelines on interaction with the private sector being followed?

When these criteria are met, GPPIs will be able to make a contribution to sustainable improvements in people's health. Without attention for participation, sustainability and accountability the good intentions of all partners involved may be jeopardised. GPPIs might then at best make a contribution to fighting an illness for a set period of time, but will not lead to the sustainable health improvements, that GPPIs are created for.

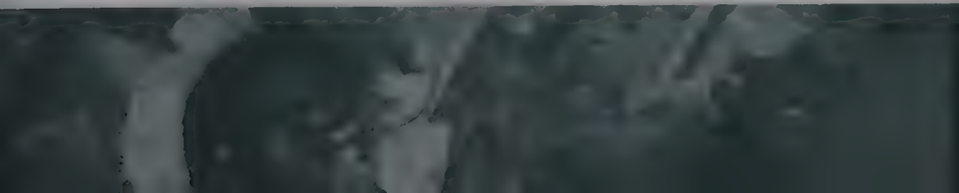
It is too early to have in-depth insight into the effects of GPPIs



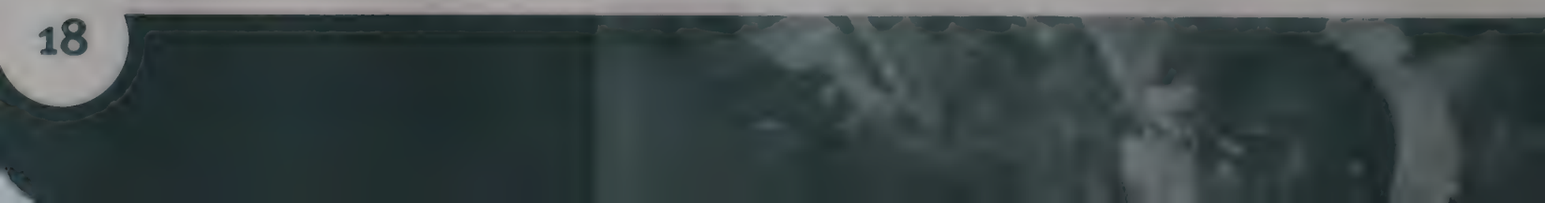
6. Annexes

Annex 1: List of the analysed GPPIs, with their targeted diseases/risk factors

Full Name	Disease / Risk Factor
Global Alliance to Eliminate Leprosy (GAEL)	Leprosy
Accelerating Access Initiative to HIV Care (AAI)	HIV/AIDS
Global Polio Eradication Initiative (GPEI)	Polio
Int'l. Partnership Against Aids in Africa (IPAAA)	HIV/AIDS
The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund)	HIV/AIDS, Malaria, Tuberculosis (TB)
Global Alliance for the Elimination of Lymphatic Filariasis (GAELF)	Lymphatic Filariasis (LF)
Global Alliance for Improved Nutrition (GAIN)	Micronutrient deficiency
Global Alliance for Vaccines and Immunisation (GAVI)	Vaccine-preventable diseases of the poor
Roll Back Malaria Global Partnership (RBM)	Malaria
Stop TB Partnership (Stop TB)	Tuberculosis (TB)
WHO-Pharmaceutical Industry Associations-NGO Anti-Counterfeit Drug Initiatives	Counterfeit and substandard drugs
African programme for Onchocerciasis Control (APOC)	Onchocerciasis (river blindness)
Meningitis Vaccine Project at WHO/PATH (MVP)	Meningitis
WHO programme to Eliminate Sleeping Sickness (WPESS)	Human African trypanosomiasis
Japanese Pharmaceutical, Ministry of Health, WHO Malaria Drug Partnership (JPMW)	Malaria
Mectizan Donation programme (Mectizan)	Lymphatic Filariasis (LF), Onchocerciasis (river blindness)
Partnership for the use of social sciences in malaria control	Malaria
Global Elimination of Trachoma (GET 2020)	Blindness, Trachoma
WHO/Novartis Coartem®	Malaria
Action TB programme	Tuberculosis (TB)
African Comprehensive HIV/AIDS Partnerships (ACHAP)	HIV/AIDS
Alliance for Microbicide Development (AMD)	HIV/AIDS, Sexually transmitted infections
Concept Foundation	Reproductive health
CONRAD	Reproductive health
Corporate Council on Africa (CCA)	HIV/AIDS
Diflucan Partnership programme	HIV/AIDS
Foundation for Innovative New Diagnostics (FIND)	Diagnostics, Tuberculosis (TB)
Global Alliance for TB Drug Development (TB Alliance)	Tuberculosis (TB)
Global Business Coalition on HIV & AIDS (GBC)	HIV/AIDS
Global Guinea Worm Eradication programme (GWEP)	Guinea worm (dracunculiasis) disease

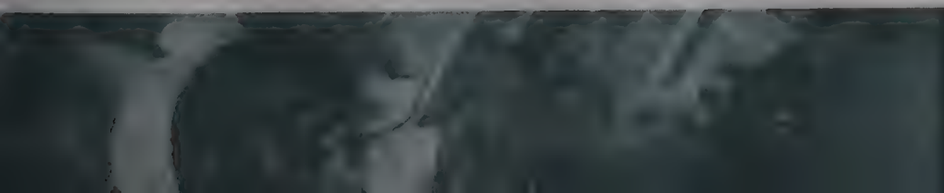


Global Microbicide Project (GMP)	Sexually transmitted infections
Global Public-Private Partnership for Hand Washing with Soap (GPHW)	Communicable diseases
Global Reporting Initiative (GRI)	HIV/AIDS
Hope for African Children Initiative (HACI)	HIV/AIDS
Intercompany Collaboration for AIDS Drug Development (ICCADD)	HIV/AIDS
International AIDS Vaccine Initiative (IAVI)	HIV/AIDS
International Partnership for Microbicides (IPM)	Sexually transmitted infections
International programme on Chemical Safety (IPCS)	Chemical safety information
Lilly Multi-Drug Resistant Tuberculosis Partnership	Tuberculosis (TB)
Maternal and Neonatal Tetanus, Global Elimination of (MNT)	Tetanus, maternal and neonatal
Microbicides Development programme (MDP)	HIV/AIDS, Sexually transmitted infections
MTCT-Plus Initiative	HIV/AIDS
Safe Injection Global Network (SIGN)	Injection safety, syringes
Secure the Future	HIV/AIDS, Sexually transmitted infections
Sequella Global Tuberculosis Foundation (SGTBF)	Tuberculosis (TB)
Step Forward programme	HIV/AIDS
Strategies for Enhancing Access to Medicines (SEAM) at Management Sciences for Health (MSH)	Diseases of the poor
Tuberculosis Diagnostics Initiative (TBDI)	Tuberculosis (TB)
UNFPA Contraceptives Access Project (UNFPA/Industry) (Profile in Progress)	Reproductive health
Viramune® Donation programme (VDP)	HIV/AIDS
Alliance for Health Policy and Systems Research (AHPSR)	Health policies and health systems
Artesunate Suppository for Emergency Treatment of Severe Malaria	Malaria
Children's Vaccine programme at PATH (CVP at PATH)	Vaccine-preventable diseases of the poor
Consortium for Industrial Collaboration in Contraceptive Research (CICCR)	Sexually transmitted infections
Dengue Vaccine Project (DVP)	Dengue
Drugs for Neglected Diseases Initiative (DNDi)	Chagas, Leishmaniasis, Human African trypanosomiasis
European Malaria Vaccine Initiative (EMVI)	Malaria
Gates Foundation/U. of North Carolina Partnership for the Development of New Drugs (GFUNC)	Leishmaniasis, Human African trypanosomiasis
Health InterNetwork (HIN)	Digital divide
Hookworm Vaccine Initiative (HVI)	Hookworm
Infectious Disease Research Institute (IDRI) Tuberculosis (TB)	Chagas, Leishmaniasis, Leprosy, Malaria,
Institute for OneWorld Health (IOWH)	Parasitic and other neglected infectious diseases
Lapdap Antimalarial Product Development (LAPDAP)	Malaria
Lassa Fever Initiative (LFI)	Lassa fever
Malaria Vaccine Initiative (MVI)	Malaria
Medecins Sans Frontieres Drugs for Neglected Diseases Working Group (MSF DND)	Neglected diseases



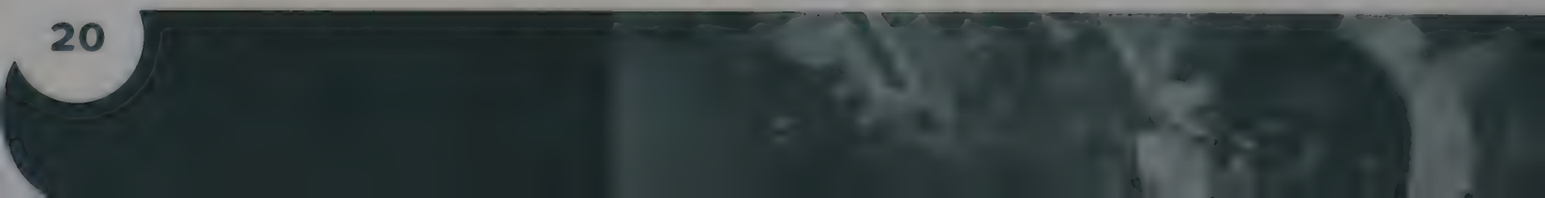
Medicines for Malaria Venture (MMV)	Malaria
International Trachoma Initiative (ITI)	Blindness, Trachoma
Int'l. Conf. on Harmonisation of Technical Reqs for Registration of Pharmaceuticals Human Use (ICH)	Harmonisation of drug applications
Micronutrient Initiative (MI)	Micronutrient deficiency
Multilateral Initiative on Malaria (MIM)	Malaria
NetMark PLUS, a Regional Partnership for Sustainable Malaria Prevention	Malaria
Pediatric Dengue Vaccine Initiative (PDVI)	Dengue
Pharmaceutical Security Institute (PSI)	Counterfeit and substandard drugs
Single Nucleotide Polymorphisms Consortium Ltd (SNP)	All human diseases and medical conditions
Vaccine Fund (VF)	Vaccine-preventable diseases of the poor
Vaccine Vial Monitors (VVMs), Development of	Vaccine vial monitors
Vision 2020	Blindness, Cataract, Onchocerciasis (river blindness), Trachoma
Vitamin A Global Initiative (VITA)	Vitamin A deficiency
Children's Vaccine Initiative (CVI) - HISTORICAL*	Vaccine-preventable diseases of the poor
Malarone Donation programme - HISTORICAL	Malaria
Meningitis C Vaccine Development and Supply in UK - HISTORICAL	Meningitis
Norplant, Development of - HISTORICAL	Reproductive health
Onchocerciasis Control programme in West Africa (OCP) - HISTORICAL	Onchocerciasis (river blindness)
Oral Rehydration Salts (ORS) Commercialisation in Bolivia - HISTORICAL	Diarrhea dehydration
Praziquantel Manufacturing Project - HISTORICAL	Schistosomiasis
Syringes - Autodestruct Development - HISTORICAL	Injection safety, syringes

*HISTORICAL means the GPPI has ended.

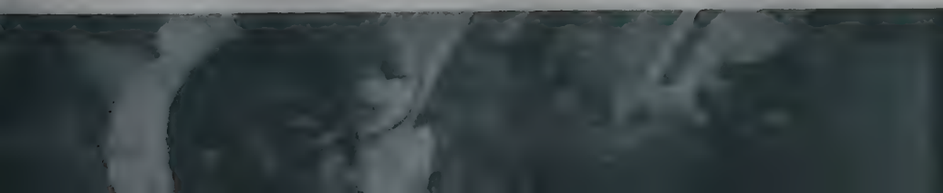


Annex 2: Overview of 10 GPPIs

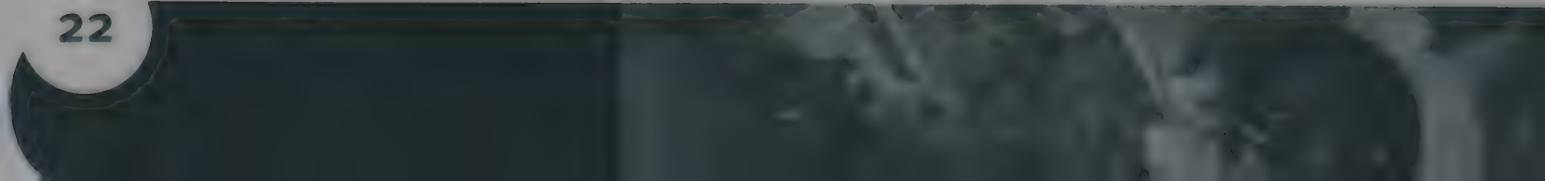
Name	**Accelerating Access Initiative to HIV Care (AAI)**
Disease or risk factor focus	HIV/AIDS
Brief description	Announced in May 2000, the initiative involves a dialogue between the UN and the pharmaceutical industry with the intention of making HIV/AIDS medicines and diagnostic equipment more available and affordable in the hardest hit regions of the world. It is a cooperative endeavour involving five UN organisations and six pharmaceutical companies. AAI is involved in negotiating deeply discounted drug prices for countries that can provide proof they have the health services to handle the complicated HIV/AIDS medicines. Facilitated by UNAIDS, governments negotiate with the pharmaceutical companies about ARV- prices.
Objectives	• To increase access to HIV/AIDS care, treatment and support in resource-poor settings • To improve access to care, including treatments for opportunistic infections and antiretroviral therapy, in the hardest-hit regions of the world
Approach	Improvement of access to health products
Main participants	**Public sector**: WHO, World Bank, UNICEF, UNAIDS, etc. **Private sector**: GlaxoSmithKline, Merck, Bristol-Myers Squibb, Abbott, Boehringer Ingelheim, Hoffman La Roche, etc.
Target countries	Bahamas, Barbados, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Chile, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Honduras, Jamaica, Mali, Malawi, Marocco, Romania, Rwanda, Senegal, Trinidad and Tobago, Uganda, South Africa
Website	www.unaids.org



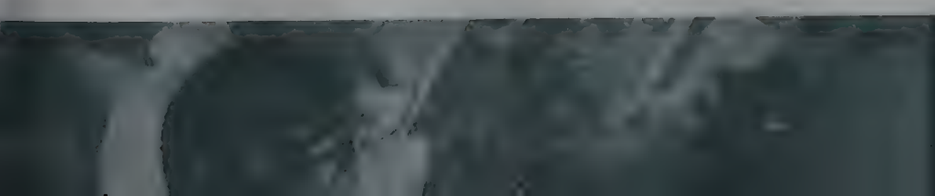
Name	**Global Alliance for Elimination of Leprosy (GAEL)**
Disease or risk factor focus	Leprosy
Brief description	The Global Alliance was initiated by WHO in 1999 to ensure that a common strategy based on experience of past leprosy elimination efforts was adopted, intensively implemented and effectively monitored. GAEL is a partnership dedicated to ensuring that all leprosy patients, wherever they may live, and however poor, have free and equal access to the most modern of treatment available. Multi-drug therapy (MDT) has been made available free of charge from WHO, thanks to a donation by Novartis which make the drugs and financial support by the Nippon and Sasakawa Foundations. MDT provides a simple yet highly effective cure for all types of leprosy in just six to twelve months. The goal of GAEL is to eliminate leprosy as a public health problem from every country by the year 2005 and to detect and cure all the remaining leprosy cases currently estimates at over 2.5 million. GAEL includes WHO, governments of endemic countries, the International Federation of Anti-Leprosy Associations, NGOs, DANIDA, the World Bank, the Nippon Foundation and the Sasakawa Memorial Health Foundation.
Objectives	To detect and cure all remaining leprosy cases (estimated at 2.8 million), in order to eliminate it from every country by 2005 (elimination as attaining a level of prevalence below one case per 10 000 population)
Approach	Improvement of access to health products
Main participants	**Public sector:** WHO, World Bank, Ministries of Health in target countries, DANIDA, etc. **Private for-profit sector:**, GlaxoSmithKline, Merck, Novartis, Binax, etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Sasakawa Memorial Health Foundation, Nippon Foundation, International Leprosy Association (ILA), International Federation of Anti-Leprosy Associations (ILEP), The Leprosy Mission (TLM), etc.
Target countries	Angola, Brazil, Guinea, India, Madagascar, Mozambique, Myanmar, Nepal
Website	www.who.int/lep



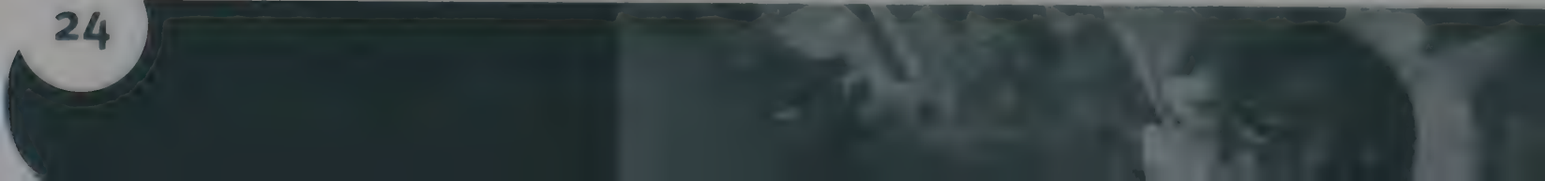
Name	Global Alliance for the Elimination of Lymphatic Filariasis (GAELF)
Disease or risk factor focus	Lymphatic Filariasis (also known as elephantiasis) Onchocerciasis (river blindness) in countries where the diseases co-exist
Brief description	GAELF exists to eliminate lymphatic filarisasis worldwide. LF is a dehabilitating condition caused by two types of parasite, spread by mosquitoes, that occupy the lymph nodes and which in conjunction with secondary bacterial & fungal infections may cause swelling of the limbs and genitals causing social stigma and restricting the ability to work and travel. In 1995 the WHR identified LF as the second leading cause of disability in the world. WHO is the secretariat for this partnership forum for the exchange of ideas & coordination of activities; with membership open to all interested parties. GAELF members include governments of endemic countries, plus 39 organisations from public and private sectors, academia, government bodies & NGOs. It was founded in May 2000. Its cornerstones are the WHO which directs and coordinates activities, the Gates Foundation, which donated $20m in 2000, and GSK which has made a $1.6bn commitment to supply drugs until the disease is eliminated.
Objectives	● To eradicate LF by 2020 ● To interrupt transmission of infection ● To alleviate and prevent the suffering and disability caused by the disease identified in more than 20m people worldwide
Approach	Improvement of access to health products
Main participants	**Public sector:** WHO, UNICEF, World Bank, US Centres for Disease Control & Prevention (CDC), Ministries of Health in target countries, USAID, UK Department for International Development (DFID), government of Belgium, Spain, Italy, Japan, Netherlands, etc. **Private for-profit sector:** GlaxoSmithKline, Merck, Binax, etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Carter Center, Arab Fund for Economic and Social Development, Caribbean Epidemiological Centre (CAREC), Secretariat for the Pacific Community, South East Asian Ministers of Education Organisation (SEAMEO), etc.
Target countries	79 countries
Website	www.filariasis.org



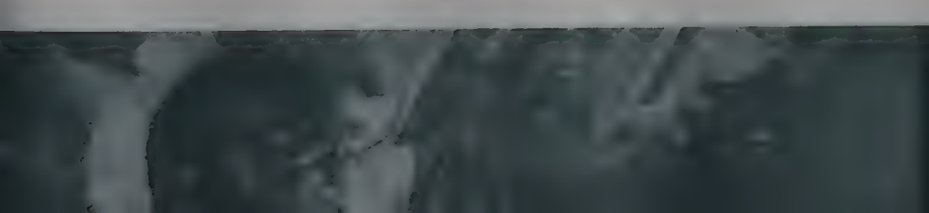
Name	**Global Polio Eradication Initiative (GPEI)**
Disease or risk factor focus	Poliomyelitis
Brief description	A multi-partner, informal coalition supporting the WHO goal and strategies for eradication of poliomyelitis. Partners include others UN Agencies, other NGOs, national development assistance and technical agencies. The spearheading partners are the WHO, Rotary International, The CDC and UNICEF. Industry has donated polio vaccine and funds to support surveillance.
Objectives	• To interrupt transmission of the wild poliovirus globally and certify all WHO regions polio-free by the end of 2005 • To achieve global certification of polio eradication, including containment of the wild poliovirus, and the development of a post-eradication immunisation policy • To contribute to health systems development by strengthening routine immunisation and surveillance for communicable diseases
Approach	Improvement of access to health products
Main participants	**Public sector:** WHO, UNICEF, World Bank, US Centres for Disease Control & Prevention (CDC), USAID, UK Department for International Development (DFID), Canadian International Development Agency, government of Finland, Germany, Netherlands, Japan, Italy, Belgium, Denmark, EU, etc. **Private for-profit sector:** Aventis Pharmaceuticals, De Beers, Wyeth, Rotary International, and Vaccine Manufacturers Network, etc. **Private not-for-profit sector:** UN Foundation, GAVI, Bill and Melinda Gates Foundation, Australian International Health Institute, Red Cross, etc.
Target countries	Afghanistan, Angola, Egypt, Ethiopia, India, Niger, Nigeria, Pakistan, Somalia, Sudan
Website	www.polioeradication.org



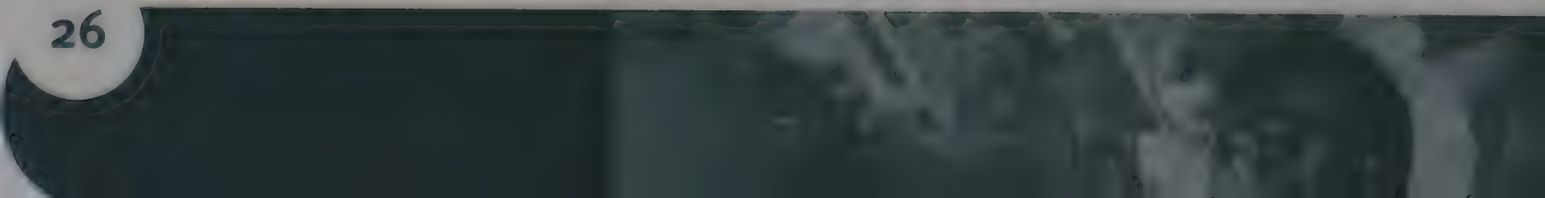
Name	Global Alliance to Improve Nutrition (GAIN)
Disease or risk factor focus	Micronutrients deficiencies
Brief description	GAIN was launched in May 2002 during the United Nations General Assemby Special Session on Children and is a collaboration between the diverse stakeholders: public sector, commercial sector, non-profit sector, bilaterals, multilaterals & academic institutions, with the emphasis on including public and private sector partners with the aim of reducing ill-health caused by malnutrition, especially deficiencies of micronutrients. It has an independent non-profit legal status. Their focus is on the promotion of food fortification programmes by food producers in collaboration with the public sector. They also promote nutrition awareness at strategic and consumer levels. They specifically exclude consideration of micronutrient supplements, leaving this to other agencies. Various activities include policy formulation, setting standards, capacity building, advocacy, marketing & operational research. As the alliance is relatively young there is no sustained period of operation during which performance can be analysed. They recognise that malnutrition is driven by social and economic factors and therefore target poor communities. GAIN is governed by a Board and administerd by a Secretariat and was incorporated as a Swiss Foundation in March 2003.
Objectives	● GAIN is an alliance of public, private and civil society organisations committed to saving lives and improving health through the elimination of vitamin and mineral deficiency. This is targeted primarily through facilitating fortification of commonly available and consumed local foods. ● By contributing to the reduction of micronutrient deficiencies, GAIN aims to decrease child and maternal morbidity and mortality, lessen health care costs, improve productivity, & promote the ability of populations to achieve their physical and intellectual potential ● A particular emphasis on children; poor communities; and vitamin A, iodine, folic acid and iron
Approach	Global coordination mechanism, public advocacy, education and research, regulation and quality assurance
Main participants	**Public sector:** WHO, Unicef, World Bank, US Centres for Disease Control & Prevention (CDC), UN Food and Agriculture Organisation (FAO), World Food Programme, USAID, Canadian International Development Agency, government of Germany, national food fortification associations, etc. **Private for-profit sector:** Procter & Gamble, Heinz, Unilever, Roche, International Life Sciences Institute, Salt Institute, etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Helen Keller International, Program for Appropriate Technology in Health (PATH), SUSTAIN, Micronutrient Initiative, PAHO, International Union of Nutritional Sciences, International Food Policy Research Institute, etc.
Target countries	Bolivia, China, Côte d'Ivoire, Dominican Republic, Indonesia, Iran, Jordan, Kazakhstan, Morocco, Nigeria, Philippines, South Africa, Thailand, Uzbekistan, Vietnam, Zambia
Website	www.gainhealth.org



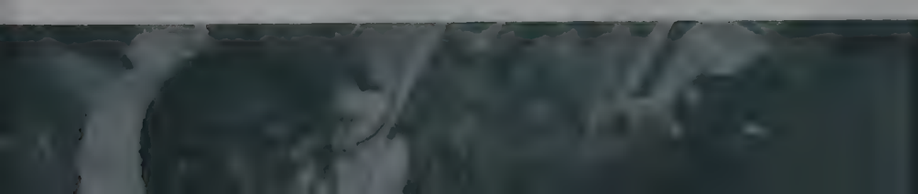
Name	**Global Alliance for Vaccines & Immunisation (GAVI)**
Disease or risk factor focus	Vaccine-preventable diseases of the poor
Brief description	GAVI was established in 1999. It partners private and public sector to improve health and "save children's lives" through the widespread use of vaccines - full vaccine coverage would save 3m lives a year. International organisations, governments, vaccine industry, research institutions, and foundations have formed a partnership to develop and push GAVI objectives. They work with the governments of target countries which are listed below and must have a GNP of less than $1000 pppa. GAVI directs the Vaccine Fund to "fuel poorer countries' long-term efforts to provide children with basic access to life saving vaccines". At the end of 2002, the Vaccine Fund had committed $905 million over five years to 64 countries in immunisation programme financing. GAVI also proposes to stimulate the vaccine industry to develop and supply vaccines vital to low-income countries. The main driver for its inception was the Gates Foundation.
Objectives	● Improve access to existing vaccine services ● Promote research and development into new vaccines ● Raise profile of vaccine-preventable diseases of the poor
Approach	Improvement of access to health products , global coordination mechanism
Main participants	**Public sector:** WHO, Unicef, World Bank, US Centres for Disease Control & Prevention (CDC), Ministries of Health in target countries, USAID, UK Department for International Development (DFID), Canadian International Development Agency, governments of The Netherlands, Norway, etc. **Private for-profit sector:** GlaxoSmithKline, Aventis, International Federation of Pharmaceutical Manufacturing Association (IFPMA), American Home Products, Chiron Vaccines, BERNA Swiss Serum & Vaccine Institute Berne, CVP at PATH, etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, United Nations Foundation, Sierra Leone Red Cross Society, Institut Pasteur, etc.
Target countries	75 countries
Website	www.vaccinealliance.org



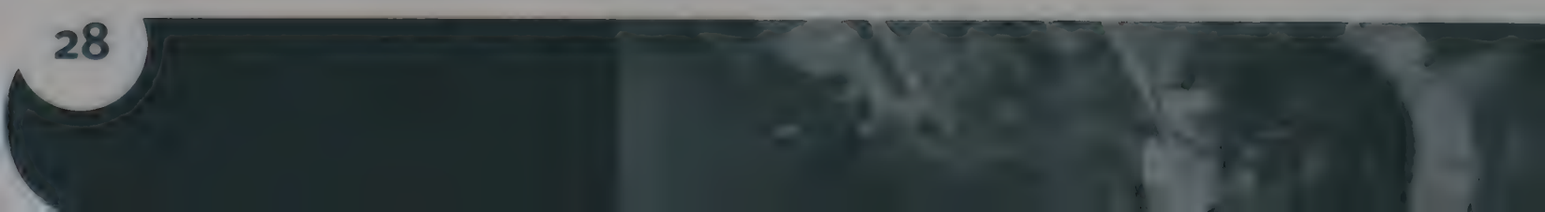
Name	**The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund)**
Disease or risk factor focus	HIV/AIDS, tuberculosis, malaria
Brief description	The Fund aims to rapidly disburse grants to increase existing spending on the prevention and treatment of these three diseases while building on, complement, and coordinate with existing regional and national programs in support of national policies, priorities and partnerships.
Objectives	In order to fight AIDS, tuberculosis and malaria: ● To attract, manage and disburse additional monies with less bureaucracy for recipient countries, allowing more effective use of donor resources, and fewer transaction costs for all ● To direct financial resources where they are needed most and ensure that they are used effectively ● Reduced death rates, reduced disease transmission rates, increased survival rate, and control of multi-drug resistance
Approach	Global coordination mechanism
Main participants	**Public sector:** WHO, World Bank, UNAIDS, USAID, governments of Thailand, Brazil, Japan, Italy, France, Ukraine, Uganda, Pakistan, China, European Union **Private for-profit sector:** may private companies e.g. McKinsey, Eni S.p.A., Statoil, Winterthur, KPMG (Thailand), Pricewaterhouse Coopers (Zambia), etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Uganda Health Rights Action Group, Harvard University, GAVI, AIDES, Academy for Educational Development, Aids Fund, International HIV/AIDS Alliance, Int. Couincil of AIDS Service organisations, Global Network of People Living with HIV/AIDS, etc.
Target countries	-
Website	www.globalfundatm.org



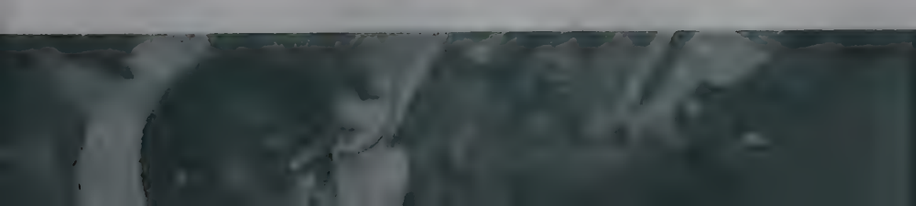
Name	International Partnership Against Aids in Africa (IPAAA)
Disease or risk factor focus	HIV/AIDS
Brief description	Established in 1999, the IPAAA is a coalition housed in UNAIDS, that works under the leadership of African countries to save and improve lives. It is made up of African governments, the United Nations, donors, and the private and community sectors. The Partnership's mission is to reduce the number of new HIV infections in Africa, promote care for those who suffer from the virus, and mobilise society to stop the advance of AIDS.
Objectives	● reduce the number of new HIV infections in Africa ● promote care for those who suffer from the virus, and mobilise society to stop the advance of AIDS ● reduce human, social and economic erosion due to AIDS in Africa
Approach	Global coordination mechanism
Main participants	**Public sector:** WHO, UNAIDS, FAO, UNDP, UNFPA, ILO (International Labour Organisation), EU, Canada, European governments (e.g. Belgium, Italy, Finland, France, Ireland, Netherlands, Norway, Sweden, UK), Japan, US, African governments, etc. **Private for-profit sector:** Boehringer-Ingelheim, Bristol Myers Squibb, Glaxo Smith Kline, Merck, F. Hoffman, Chevron Oil, Eskom, Rio Tinto etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Rockefeller Foundation, McArthur Foundation, Packard Foundation, Ted Turner, African Council of AIDS Service Organisations, Network of people living with HIV/AIDS (NAP+), Society of women with AIDS in Africa (SWAA), etc.
Target countries	-
Website	www.unaids.org



Name	**Roll Back Malaria (RBM)**
Disease or risk factor focus	Malaria
Brief description	RBM is a WHO-led programme - a 'global partnership' - that aims to act as global coordinator for malaria prevention & treatment efforts: specifically, "aims to provide global leadership, strategy, and overall coordinating mechanisms ". It proposes to "halve the world's malaria burden by 2010" and acknowledges the profound economic and human impact that malaria has on the poor, especially in sub-Saharan Africa. It was founded in 1998 by four multilateral institutions: WHO, UNICEF, UNDP & the World Bank, possibly in a reaction to the perceived failure of the WHO's previous malaria control strategies from the last 40 years. It is not a fund. It coordinates other stakeholders, other alliances, and funds. From inception in 1998 its aim has been to apply a new type of management structure to the application of disease-specific programmes at WHO: more flexible, less top-heavy, faster at making decisions.
Objectives	• Increase global political commitment to tackle malaria more effectively through coordinated action • Assist the health sector to focus resources on high disease burdens such as malaria and cost-effective intervention packages and increase commitment among the research community and private sector • Discover new products and cost effective control tools
Approach	Global coordination mechanism, health services strengthening
Main participants	**Public sector:** WHO, Unicef, World Bank, US Centres for Disease Control & Prevention (CDC), UNDP, Ministries of Health in target countries, USAID, UK Department for International Development (DFID), Canadian International Development Agency, governments of Australia, Denmark, Ireland, Norway, Sweden, The Netherlands, etc. **Private for-profit sector:** GlaxoSmithKline, Novartis, Eni, ExxonMobil, Procter & Gamble, World Alliance for Community Health (founder members are mining companies), etc. **Private not-for-profit sector:** Bill and Melinda Gates Foundation, Medecins Sans Frontieres, Child Survival Collaborations and Resources Group, Red Cross, Oxfam, MERLIN, Netmark, Malaria Consortium UK, Multilateral Initiative on Malaria, Medicines for Malaria Venture, Malaria Vaccines Initiative, Royal Tropical Institute, Netherlands, London School of Tropical Medicine, etc.
Target countries	103 countries
Website	www.rbm.who.int



Name	**Stop TB Partnership**
Disease or risk factor focus	Tuberculosis
Brief description	Stop TB is a partnership that is hosted by the WHO with the aim of eradicating TB worldwide within the next 50 years or so. Its function is to lead, coordinate, strategise and plan interventions worldwide. DOTS is the central plank of its strategy. It recognises the social, political and economic factors that lie behind the disease TB. It has a strong focus on the link between HIV and TB. Countries include target countries, bilaterals and multilaterals, academic institutions (teaching & research), TB associations, NGOs & commercial pharmaceutical companies. Governance is addressed by the Stop TB Framework and plans and activities are coordinated by the Stop TB Coordinating Board. Founded in 1998.
Objectives	Build partnerships to accelerate social and political action to stop the unnecessary spread of tuberculosis around the world
Approach	Global coordination mechanism
Main participants	**Public sector:** WHO, Unicef, World Bank, US Centres for Disease Control & Prevention (CDC), TDR, Ministries of Health in target countries, USAID, UK Department for International Development (DFID), Canadian International Development Agency, US National Institutes of Health (NIH), governments of Japan, Netherlands, UK, etc. **Private for-profit sector:** Pan American Institute of Highways, Soros Foundation, Wyeth, Ryder-Cheshire, etc. **Private not-for-profit sector:** Management Sciences for Health, Royal Netherlands Chemical Society, International Union Against Tuberculosis And Lung Disease, American Lung Association, Royal Netherlands TB Association, Tuberculosis Research Centre, India, Research Institute of Tuberculosis, Japan, Sao Paolo University, etc.
Target countries	Afghanistan, Bangladesh, Brazil, Cambodia, China, The democratic republic of the Congo, Enthiopia, India, Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Pakistan, Philipines, Russian Federation, South Africa, Tanzania, Thailand, Uganda, Vietnam, Zimbabwe
Website	www.stoptb.org



7. Interesting websites

www.wemos.nl/english
www.ippph.org
www.haiweb.org
www.gatesfoundation.org
www.who.int

8. References

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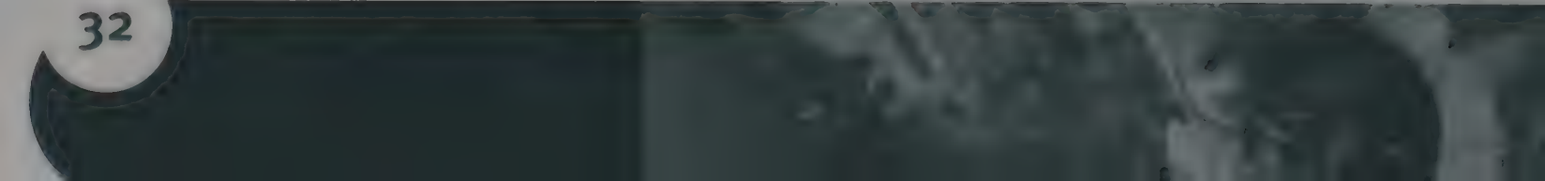
9. Explanation of words and abbreviations

Accountability	Providing an explanation for or justification of one's actions.
Civil society	Civil society covers the space between the activities of the state and the market. Organisations within civil society range from church groups to environmental pressure groups to local credit collectives and trade unions.
Cold chain	The equipment and people that keep vaccines cold, from the manufacturer to the child. This includes vaccine refrigerators and vaccine carriers. A cold chain failure, where vaccines have not been kept at specified temperature, can result in vaccines losing their potency.
Empowerment	The conferment of a sense of self-actualization or authority to an individual, group of individuals or an organisation
Generics	Drugs not protected by trademark (Example:`Acetaminophen' is the generic form of
the	proprietary drug`Tylenol')
GPPI	Global Public Private Initiative: a collaborative relationship that transcends national boundaries and brings together at least three parties – among them a corporation and/or industry association and an intergovernmental organisation – so as to achieve a shared health creating goal on the basis of mutual agreed and explicitly defined division of labour
Health systems	The combination of a set of cultural beliefs about health and illness that forms the basis for health seeking and health promoting behaviour, the institutional arrangements within which that behaviour occurs, and the socio-economic, political and physical context for those beliefs and institutions. Or: all activities whose primary purpose is to promote, restore or maintain health (WHO 2000).
Low and lower middle income countries	A country having an annual gross national product (GNP) per capita equivalent between 735 US dollar and 2935 US dollar in 2002. At that time, there were about 64 low-income countries and 54 lower middle income countries.
Multilateral organisations	International institutions with governmental membership,spanning several regions, including financial institutions such as the World Bank and IMF, UN agencies and regional groupings.



NGO	Non-Governmental Organisation: not belonging to orassociated with a government
Pentavalent	A pentavalent vaccine combines 5 different vaccine antigens that can be given as a single shot; in this case it is the addition of Hepatitis B vaccine and Haemophilus influenzae type b vaccine to the existing Diphtheria-Tetanus-Pertussis (DTP) vaccine
Private sector	The private sector is composed of all the organisations and individuals outside the direct control of the state, including both those working for-profit and not-for-profit
Quadravalent	A quadravalent vaccine combines 4 different vaccine antigens that can be given as a single shot; in this case it is the addition of Hepatitis B vaccine to the existing Diphtheria-Tetanus-Pertussis (DTP) vaccine
Public health	The general health of a community and the practice and study of ways to preserve and improve this. It includes health education, sanitation, control of diseases, and regulation of pollution.
Sustainability	The ability to autonomously continue an intervention after external financial and technical assistance ceases
TB	Tuberculosis
Transnational Corporations (TNCs):	Companies which operate in more than one country but retain ownership and control in their home countries
Transparency	In the case of GPPIs, it means that information is open and accessible to everyone and that decisions are taken democratically
UN	United Nations
WHO	World Health Organisation
WHO guidelines on working with the private sector	Guidelines intended primarily to help WHO staff interact appropriately with commercial enterprises and avoid conflict of interest

10. About this publication

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Financial contributions
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Stichting Doen, ICCO, Cordaid
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It is permitted to use information from this publication provided that reference is made to the source.

This publication does not necessarily reflect the opinion of our funders. Wemos is solely responsible for the content of this publication.

March 2004

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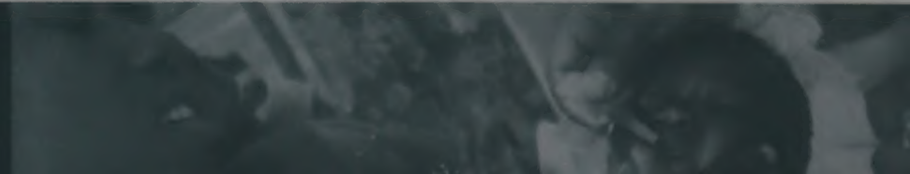

The highest attainable standard of health is a fundamental Human Right.
Wemos Foundation has been working since 1981 to improve people's health
in developing countries through influencing international policy.

WEMOS

GEZONDHEID WERELDWIJD

HEALTH FOR ALL

This booklet provides information on the background and working of Global Public Private Initiatives in health – GPPIs, which aim to improve the health situation in poor countries. It also contains some critical remarks of the Wemos Foundation.